SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

Apex Physical Therapy, PLLC

Effective Date: April 1, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Please review the full Notice of Privacy Practices (NPP) which is attached. If you have any questions about this notice, please contact Robert M. Paull, Privacy Officer at (509) 465-1749.

WHO WILL FOLLOW THIS NOTICE:

- Apex Physical Therapy, PLLC
- Apex Physical Therapy – North
- Apex Physical Therapy – Cheney
- Apex Physical Therapy – Airway Heights
- Apex Physical Therapy - Fairways

This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal physical therapist or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to health information about you, and:
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

There are also various other ways in which we may use or disclose your information:

- **Appointment Reminders**
- **Research**
- **To Allow Oversight of the Quality of the Healthcare We Provide**
- **To Allow Workers' Compensation Claims**
- **As Required by Subpoena in Lawsuits and Disputes**
- **Various Uses as Required by Law or to Avert a Serious Threat to Health or Safety**

The full details for all these uses are contained in the full NPP.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy**
- **Right to Amend**
- **Right to an Accounting of Disclosures**
- **Right to Request Restrictions**
- **Right to Request Confidential Communications**
- **Right to a Paper Copy of This Notice**

Information on how to exercise these rights can be seen in the NPP or can be obtained from Robert M. Paull, Privacy Officer at (509) 465-1749

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Robert M. Paull, Privacy Officer. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

Financial Policy and Agreement

The following is an explanation of Apex Physical Therapy's financial policy and agreement, which we ask you to read prior to any evaluation and treatment.

Initial Here

_____ Payment of all insurance **CO-PAYS ARE DUE AT EACH VISIT – WE CANNOT BILL YOU FOR A CO-PAY.** Should a parent not accompany their child to therapy, they need to send payment with them or make arrangements with the billing office to charge it to a credit card.

_____ **High deductible plans require a $50.00 payment towards each visit costs.** This is an **estimate only**, not an exact figure. There is a **high likelihood that you will still be responsible for an additional balance** once your insurance has processed your claim.

_____ **Patients with CO-INSURANCE will be required to pay at time of service.** This is an estimate only and there may be an additional balance once your insurance has processed your claim.

_____ As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. **It is the patient's responsibility to determine what the insurance company will allow for physical therapy and obtain approval if necessary.**

_____ **INSURANCE COVERAGE IS NEVER GUARANTEED.** Your insurance company determines benefits when claims are received**. Any quotes of benefits or coverage made by staff of Apex Physical Therapy, in no way guarantees payment by your insurance company. You will be responsible for any balances not paid by your insurance.**

_____ We will bill your auto insurance following a motor vehicle accident. However, patients are required to call prior to their first visit to Apex and verify the amount of Personal Injury Protection (PIP) remaining. If PIP coverage is exhausted, Apex will bill your medical insurance. After medical insurance has paid their portion of the claim, you will be responsible for the balance remaining.

Your bill is your responsibility, whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.

We do participate with most insurance companies. However, some plans require a referral from your primary care physician. A written referral and any required preauthorization must be on file prior to each office visit.

Patients who do not have medical insurance are required to pay the total balance at time of each service.

Statements are sent out once a month. Patients are expected to pay account balances in full each month.

Patients who do not remit payment within 30 days of receiving their first statement, will be contacted by our billing department. You will be required to pay your balance prior to your next scheduled appointment.

Accounts that have not been paid within 60 days will be sent to an outside collection agency.

Patients whose accounts have been sent to the collection agency will forfeit the opportunity to be treated in the future.

Account balances must be paid in full prior to the onset of a new course of treatment.

Cancellations within 24 hours of the appointment or a No Show can result in a $35.00 charged billed directly to you, not your insurance company.

If you fail to attend two appointments (either by failing to show up for your appointment or not giving sufficient cancellation notice), you may be discharged from our practice.

Please be on time for your appointments - if you are late, your treatment time may be shortened or may be rescheduled.

Supplies: Supplies purchased by the patient are payable at the time of service. Supplies are not returnable or refundable. We **DO NOT BILL INSURANCES FOR SUPPLIES.**

We accept Cash, Checks, Visa and MasterCard

Our Billing Office Staff are willing to help you with explanation of charges and insurance payments. Please contact them at 465-5170.

Patient Release and Consent to Treat

I hereby consent to evaluation and treatment by my physical therapist at *Apex Physical Therapy, PLLC*. I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent.

I understand that Apex Physical Therapy is not responsible for any personal belongings that I bring into the clinic.

I understand that I am **FINANCIALLY RESPONSIBLE** for all charges for services rendered regardless of litigation, insurance reimbursement, or pending L&I claims.

I understand that the parent accompanying a minor for treatment will be responsible for payment. I authorize Apex Physical Therapy and its subsidiaries to release any necessary information requested by my insurance carrier and authorize payment directly to Apex Physical Therapy and its subsidiaries for any benefits available under my insurance plan.

I acknowledge that I have read, I understand and I consent to the financial policy and agreement, the cancellation/no-show policy, The HIPAA notice of privacy practices, and the patient consent to treat stated above.

_____

Patient's Printed Name

_____ _____

Patient's Signature (Parent or Guardian's signature) Date

Cancel No Show Policy

If a patient cancels the day of their appointment or does not show for their appointment, a $35.00 charge will be billed directly to that patient, not their insurance company. This charge will need to be paid before the next visit or appointments will be cancelled.

Life Time Authorization for Medicare and or other Insurances

I request that payment under the medical insurance program be made to the provider named below on any bills for services furnished to me. I authorize the below-named provider to release to the Social Security Administration, its intermediaries or carrier's information needed for the claim or any related Medicare Claim. I acknowledge that I have read and understand the Medicare Authorization. I further permit a copy of this authorization to be used in place of the original.

Provider's Name: Apex Physical Therapy, PLLC

Provider's Address: 1111 E Westview Ct Ste A
Spokane, WA 99218

_____

Patient's Printed Name

_____ _____

Patient's Signature Date

Spokane
1111 East Westview Ct., Suite A
Spokane, WA 99218
www.apexpt.com

Phone 509-465-1749
FAX 509-465-1748

Cheney
1855 First Street
Cheney WA 99004
www.apexpt.com

Phone 509-559-5038
FAX 509-559-5027

Airway Heights
12721 W 14th Avenue
Airway Heights, WA 99001
www.apexpt.com

Phone 509-244-9968
FAX 509-244-9914

Fairways Plaza
10511 W Aero Suite 1
Spokane, WA 99224
www.apexpt.com

Phone 509-413-2140
Fax 509-413-2141

Dear Patient,

Welcome to Apex Physical Therapy. We look forward to working with you to overcome your dizziness, vertigo, and/or imbalance. There are a few things that we would like you to consider prior to your first physical therapy visit:

1. It is best to come to your initial appointment at the time of day that your symptoms are most present, or at their worst.
2. From that point on, schedule your appointments at times that are convenient for you, at a consistent time of day if possible.
3. Have your doctor's office send over the results of any special tests you have had. For example: ENG, rotary test, posturography, caloric test, MRI, etc…
4. Bring a list of the current medications you are taking.
5. Complete the enclosed paperwork **prior** to your first physical therapy visit and bring it with you to the appointment.

Thank you. Please feel free to contact us if you have any questions.

Sincerely,

Apex Physical Therapy

MEDICAL HX SCREEN (VESTIBULAR)

1) Name:_____
LAST FIRST M.I.
2) Birth date: _____
3) Primary Care Provider: _____
Referring Doctor (if other): _____
4) Employment:
□ Full Time □ Student
□ Part Time □ Homemaker
□ Retired □ Unemployed
Occupation: _____
5) Do you live alone? □ Yes □ No
6) Where do you live?
□ One level home □ Apartment (2 stairs)
□ Split entry □ Apartment (3 stairs)
□ Two Story home □ Assisted Living
□ Other (specify): _____

7) What assistive devices do you use/have available?
□ Walker □ Raised Toilet seat □ Crutches
□ Contacts/Glasses □ Wheelchair □ Cane
□ Hearing device □ Motorized Wheelchair
□ Ramps
□ Other (braces, AFO): _____

CURRENT/GENERAL HEALTH

1) Overall Perceived Health
□ Excellent □ Good □ Fair □ Poor
2) How often do you exercise?
□ >5x/week □ 3-4x/week □ <3x/week □ Rarely
3) Do you smoke? □ Yes □ No
Estimated packs/day: _____
If not currently, quit date: _____
4) Alcohol?
Days/week you drink _____.
How many drinks/day _____.

FAMILY HISTORY

Indicate medical history of relative (mother, father, brother, sister, etc.) if applicable or known.
1) Cancer_____
2) Hypertension_____
3) Diabetes_____
4) Stroke_____
5) Heart Disease_____
6) Inherited disorder (name if able): _____
_____
7) Other_____

YOUR MEDICAL HISTORY (check all that apply)

□ Arthritis □ Broken bones/Fractures
□ Osteoporosis □ Diabetes Type I__ II__
□ Cancer □ Heart/Lung Disorders
□ Allergies □ Muscular dystrophy
□ Asthma □ Epilepsy/Seizures
□ Depression □ Kidney difficulties
□ Vascular Issues □ High Blood Pressure
□ Thyroid □ Low blood sugar
□ Skin diseases □ Infectious diseases
□ Blood disorders □ Parkinson's Disease
□ Multiple Sclerosis
□ Other (please specify) _____

SURGICAL HISTORY

1) Have you ever had surgery? □ Yes □ No
Applicable dates/procedures
a)_____
b)_____
c)_____
d)_____
e)_____

Over the past year, have you experienced or are currently experiencing any of the following symptoms?

□ Excessive weight loss/gain □ Chest Pain
□ Difficulty Sleeping □ Night Pain
□ Balance/Coordination Problems □ Blackouts
□ Dizziness/Fainting □ Frequent Falls
□ Shortness of breath □ Fever/Sweats
□ Bowel/Bladder problems □ Headaches
□ Hearing/Vision difficulties □ Joint Pain
□ Ringing in the ears □ Loss of appetite
□ Nausea/Vomiting □ Weakness
□ Heart Palpitations
□ Difficulty swallowing
□ Other_____
□ Does your PCP know about these complaints?

MEDICATIONS

1) Please list all current medications you are taking:
_____
_____
_____
_____
_____

2) Are you taking any non-prescription meds or over the counter medications? □ Yes □ No

Please check all known clinical tests you have undergone in the past year.

□ Bone Scan
□ MRI
□ X-rays
□ Ultrasound
□ Stress Tests
□ EMG
□ EKG
□ EEG
□ ENG
□ CT Scan
□ Myelogram
□ Caloric Test
□ Nerve Conduction Velocity
□ Pulmonary Function Test
□ Angiogram/Arterial Scan
□ Arthroscopy
□ Biopsy
□ Blood Tests
□ Bronchoscopy
□ Rotary Test
□ Echocardiogram
□ Mammogram
□ Urine Tests
□ Posturography
□ Other (please specify):

_____

Any difficulty/abnormal finding that you have experienced over the past year, that you may or may not associate with your current symptom that you are concerned about? □ Yes □ No
Specify: _____
_____

SPECIAL QUESTIONS

1) Are you or could you be pregnant?
□ Yes □ No □ N/A

2) Complicated pregnancies in the past? □ Yes □ No

3) Any gynecological/obstetrical difficulties?
□ Yes □ No

CURRENT/CHIEF COMPLAINT

1) Why are you seeking Physical Therapy Intervention? _____

_____

2) Date when pain/injury began:
MONTH DAY YEAR
__ __ __ __ __ __ __ __

3) CAUSES OF SYMPTOMS (IF KNOWN): _____
_____
_____

Vestibular Disorders (check diagnosis):
□ BPPV / BPPN
□ Hydrops
□ Labyrinthitis
□ Ototoxicity
□ Acoustic neuroma
□ Age related degeneration
□ Meniere's Disease
□ Neuritis
□ Fistula
□ Vertigo

1) Have you had a similar problem in the past?
□ Yes □ No
If so, what? _____
How long did it last? _____
Did you seek treatment? _____

2) Activities you are unable to do due to symptoms
_____
_____
_____

3) Next scheduled doctor recheck appointment
_____

4) Treatment for current condition?
_____
_____
_____

5) Pertinent accidents or injuries and dates
_____
_____

6) Have you or are you going to see any other healthcare providers for you current condition? Check all that apply.
□ Another physical therapist
□ Acupuncturist
□ Chiropractor
□ Dentist
□ ENT
□ Family Practitioner
□ Massage Therapist
□ Audiologist
□ Rheumatologist
□ Occupational therapist
□ Orthopedist
□ Osteopath
□ Optometrist
□ Pediatrician
□ Podiatrist
□ Neurologist
□ Other: _____
_____

15) Any special needs you require?
Please be specific: _____
_____
_____

Signature:_____

Date: _____

Patient Name: _____ Date:_____

Dizziness Handicap Inventory

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "yes", "no", or "sometimes" to each question.
Answer each as it pertains to your dizziness or unsteadiness problem only.

Item	Response
P1. Does looking up increase your problem?	_____
E2. Because of your problem, do you feel frustrated?	_____
F3. Because of your problem, do you restrict your travel for business or recreation?	_____
P4. Does walking down the aisle of a supermarket increase your problem?	_____
F5. Because of your problem, do you have difficulty getting into or out of bed?	_____
F6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or going to parties?	_____
F7. Because of your problem, do you have difficulty reading?	_____
P8. Does performing more ambitious activities, like sports, dancing, household chores (sweeping or putting dishes away) increase your problem?	_____
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	_____
E10. Because of your problem, have you been embarrassed in front of others?	_____
P11. Do quick movements of your head increase your problem?	_____
F12. Because of your problem, do you avoid heights?	_____
P13. Does turning over in bed increase your problem?	_____

Patient Name: _____ Date: _____

F14. Because of your problem, is it difficult for you to do strenuous homework or yard work? _____

E15. Because of your problem, are you afraid that people may think you are intoxicated? _____

F16. Because of your problem, is it difficult for you to go for a walk by yourself? _____

P17. Does walking down a sloped sidewalk or ramp increase problem? _____

E18. Because of your problem, is it difficult for you to concentrate? _____

F19. Because of your problem, is it difficult for you to walk around you house in the dark? _____

E20. Because of your problem, are you afraid to stay at home alone? _____

E21. Because of your problem, do you feel handicapped? _____

E22. Has your problem placed stress on your relationships with members of your family or friends? _____

E23. Because of your problem, are you depressed? _____

F24. Does your problem interfere with your job or household responsibilities? _____

P25. Does bending over increase your problem? _____

DIZZINESS AND BALANCE QUESTIONNAIRE

NAME_____ **AGE**_____ **DATE**_____

Please circle the word(s) that best describe your symptoms:

Spinning	disoriented	swimmy	fullness in ears	off balance
Rocking	lightheaded	woozy	ringing in ears	blurred vision
Nausea	blacking out	leaning	falling	drunk

When did your symptoms start? _____

Are they getting: better? worse? not changing?

DIZZINES

Is your dizziness constant or does it come and go? _____

How often does your dizziness occur? _____

How long does your dizziness last? seconds minutes hours days

Does anything make your dizziness better? _____

Does anything make your dizziness worse? _____

List any medications you take for your dizziness: _____
_____

BALANCE

Please circle the activities that you have difficulty with:

Walking a straight path	making quick turns	looking around when you walk
Bending over	looking up	walking on uneven ground
Walking at night	standing unsupported	

How frequently do you loose your balance? 1-3x/day 1-3x/week 1-3x/month

How frequently do you fall? None 1-3x/day 1-3x/week 1-3x/month

GENERAL

Do you have any pain, related or not to your current problem? **Yes** **No**
How severe? **None** 0 1 2 3 4 5 6 7 8 9 10 **Severe**
Where? _____ Describe:_____
What aggravates it?_____ what relieves it? _____

DESIRED OUTCOME:
What is your goal in coming to physical therapy? _____
_____